STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

Behavioral Health Program

Mental Health Agency License Application

SECTION 1: Facility Information			
Facility/Agency Name:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:		State Tax ID or Employer ID No.:	

SECTION 2: Fees

APPLICATION FOR MENTAL HEALTH AGENCY LICENSE

License Type (select all that apply): ☐ New License (Fee $25.00) ☐ Renewal License (Fee $25.00) - **Current License #** _____ **Total Fee for License……**	$ 25.00
☐ Add new Module(s) (fee $25.00 x # Module(s) checked below: _____) ☐ Community Support Services ☐ Crisis Residential Services ☐ Emergency Services ☐ Outpatient Therapy ☐ Residential Progress ☐ Social Club **Total Fee for Module(s)…….**	$_____
☐ Add Site(s) or Service(s) to an existing license: $10.00 x _____ school(s) $25.00 x _____ service(s) If listing Service(s), please list the type of service(s): _____ _____ **Total fee to add for existing license……**	$_____
Make check or money order payable to "Treasurer, State of Maine." Do not send cash. Credit Cards are not accepted at this time. **Total Check/Money Order Enclosed……**	$_____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Behavioral Health Program
41 Anthony Ave, 11 State House Station, Augusta, ME 04333-0011
Tel: (207) 287-4399 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine Relay 711
Email: info.dhhs@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SECTION 3: Facility Contact Information			
Name and Title of Primary Contact Person:			
Telephone No.: ( )	Email Address:		
Name and Title of Administrator/Operator:			
Telephone No.: ( )	Email Address:		
Name and Title of Executive Director:			
Telephone No.: ( )	Email Address:		
Corporation Name (if applicable):			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )	Fax No.: ( )		

SECTION 4: Facility Information

Accreditation:

Is the facility accredited?

- ☐ No
- ☐ Yes, Please indicate which accrediting agency: _____

How many years have the facility held this accreditation? _____

Type of facility:

- ☐ Individual Proprietorship
- ☐ Non-Profit Corporation
- ☐ Tribal Government
- ☐ Church
- ☐ Partnership
- ☐ Parent Co-Op
- ☐ Other (describe): _____

Request: If you are requesting a waiver /exception/extension, please describe below:

_____

_____

_____

_____

_____

_____

SECTION 5: Staff Roster
Complete the following information. Use additional paper if necessary.

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

SECTION 6: Services being applied for
Complete the following information. Use additional paper if necessary.

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

Module:		Service:
Age Range:	Gender:	Number of Clients:
Address:		

SECTION 7: Submission

Remember to submit the following documents with your completed application:

- A check or money order made payable to "Treasurer, State of Maine"
- Fire Inspection Form (required for ALL new sites) - Appendix A
- Organizational chart
- List of governing body members/offices held/addresses
- Staff roster
- ADA Self-Evaluation Form (new sites only)
- Program descriptions
- Program admission criteria for each program
- Any new or changed policies
- Submit current water test for each site not on public water

In addition, first time applicants must also submit:

- Articles of Incorporation
- Assurance of Compliance (ADA/EEO)
- Complete Policy and Procedures Manual
- Sample client file

SECTION 8: Declaration

I/We have received and read the rules for the licensing process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make visits and inspections as needed to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office concerning named on application. I/We understand any falsification of statement may be grounds for denial.

I/We further certify that all information contained in this application (including Appendix) is complete and accurate.

_____	_____	_____
Print name of Applicant/Operator/Administrator	**Signature of Applicant/Operator/Administrator**	**Date**
_____	_____	_____
Print name of 2nd Applicant (If Applicable)	**Signature of 2nd Applicant (If Applicable)**	**Date**
_____	_____	_____
Print name of Board President (If Applicable)	**Signature of Board President (If Applicable)**	**Date**

Fire Inspection Request and Address Change Form
Type of License: MENTAL HEALTH AGENCY

Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one (1) form for each site from which you plan to deliver services and return with your application. (Complete a separate form for each site).
2. All Applicants: Complete and submit form when you are adding a new site, changing your address, or closing a site. (Retain a copy of this form for your records).

MAIN SITE:
Agency Name: _____ Date: _____
Operator/Executive Director: _____ Telephone: _____
Address: Contact Person (if different):
_____ _____
_____
_____ Phone: _____
(City, State, Zip)

Description of Services: _____
_____

Age Range of Clients Served: _____ Maximum Capacity: _____

Residential: _____ Non-Residential: _____

Directions to Facility: (Be specific with known landmarks.) _____
_____
_____
_____

COMPLETE ONLY IF CHANGE:
Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

New Program/Agency In Process of Licensure: ☐ No ☐ Yes, date of submitted application: _____

☐ Closing Existing Site Current Address: _____
_____

☐ Moving Office Site within Same Building _____

☐ Adding New Site New Address: _____
_____

Date of Expected Move: _____
Contact Person: _____ Telephone: _____

Water Source: ☐ Municipal ☐ Well ☐ Other: _____

Directions to Facility: (Be specific with known landmarks.) _____
_____
_____